Prudential Financial

Group Term Life Insurance Portability Election Form

If you have been actively employed prior to leaving your employer, and you are not retiring or disabled, you may apply for Group Term Life Insurance coverage under Prudential's portability option.
This option may be available to you and your covered dependents (if you continue your coverage). Portable coverage terminates according to the terms of the group portability contract, however coverage will not be continued beyond age 80.

When To Apply

You must apply for the Portability Option within 31 days of your coverage termination date.
If you apply within 31 days, there will be no lapse in your coverage.

How To Apply

1. Your employer completes Sections 2 and 3 of the Portability Election Form.
2. You need to complete Sections 1, 4, 5, 6, 7, and 8 of the Portability Election Form. Please designate a beneficiary in Section 5 since this form replaces your previous beneficiary form. You are automatically the beneficiary for any dependent coverages. If your spouse elects portability as a result of a divorce, he/she should designate their own beneficiary.
3. To apply for preferred premium rates, you and your spouse must each complete the attached Short Form Health Statement Questionnaire. If you do not complete this form, or if it is not approved by Prudential, your rate (and your spouse, if applicable) will be higher than if you had completed the statement and Prudential approved your statement.
4. Return the completed form(s) to this address:

   The Prudential Insurance Company of America
   Group Life Record Keeping
   P.O. Box 13676
   Philadelphia, PA 19176

5. Portability may be available for dependent spouse and children (without an employee porting) if due to divorce (spouse only) or the death (spouse and child) of the employee.

Confirmation of Coverage

After you have completed all of the above steps, Prudential will send you a billing statement within six weeks, which will confirm that your coverage is in effect. All payments must be made promptly to prevent lapse or termination of your Group Term Life Insurance coverage. Electronic Funds Transfer (EFT) is available as an option to pay premiums once payment of your initial billing statement is received. You can contact Prudential at the toll free number indicated below for further details or to request an EFT authorization form.

If You Have Questions

If you have questions, you may contact Prudential Group Life Recordkeeping at **800-778-3827**.

Group Term Life Insurance Coverage Portability Election Form*

Please return this form to:
The Prudential Insurance Company of America
Group Life Record Keeping
P.O. Box 13676
Philadelphia, PA 19176

1. Employee/Applicant Data (to be completed by employee/applicant)

Last Name	First Name	MI	Sex: ☐ Male ☐ Female
Street Address	Apartment #	City	State ZIP
Date of Birth	Social Security Number	Daytime Phone Number	Home Phone Number
Email Address		Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widower	

2. Group Term Life Insurance Coverage Amount(s) (to be completed by employer)

Complete all blocks. If your current Optional Term plan does not include some of the options below (e.g. Accidental Death and Dismemberment (AD&D) or Dependent Term Life), or the employee is not enrolled in the option or the option is not eligible for portability based on your contract, please indicate 'not applicable' (**NA**).

Coverage Termination Date	Reason and Date of Termination of Employment
Salary and Date of Last Day Actively at Work	Group Contract Number
Current Optional Term Life Coverage Amount – Employee $	Current Optional AD&D Coverage Amount – Employee $
Current Dependent Term Life Coverage Amount – Spouse $	Current Optional AD&D Coverage Amount – Spouse $
Current Dependent Term Life Coverage Amount – Children $	Current Optional AD&D Coverage Amount – Children $

I certify that, to the best of my knowledge and belief, the information provided in Section 2 is correct and the employee who is named on this form is eligible for portability according to the terms specified in the Prudential group contract.
Signature of Employer Representative (employer certification for portability eligibility)

X **Date** **Representative Phone Number**

3. Assignment Data (to be completed by employer)

Has this insurance been assigned? ☐Yes ☐No **If NO, sign the certification at the bottom of this section. If YES, complete this section with assignee or trustee information and attach copy of the assignment form.**

Last Name of Assignee or Trustee	First Name	MI		
Street Address	Apartment #	City	State	ZIP
Daytime Phone Number	Home Phone Number	Social Security Number or Tax Identification Number		

I certify that, to the best of my knowledge and belief, the assignment information provided above is correct.
Signature of Employer Representative (employer certification of assignment information)

X **Date**

4. Group Term Life Insurance Coverage Amount(s) (to be completed by employee/applicant)

Please note: If you are eligible for AD&D coverage, any amounts elected must be equal to or less than the group term life amount. All insurance amounts will be rounded down to the nearest $1,000. Coverage amounts will be reduced by any accelerated benefits paid under the Accelerated Benefit Option.

Optional Term Life and Dependent Term Life Coverage	**Optional AD&D Coverage**
Employee (Optional Term Life Insurance): Retain current face amount ☐ $ _____ Elect lower amount ☐	**Employee:** Retain current face amount ☐ $ _____ Elect lower amount ☐
Spouse (Dependent Term Life Insurance): Retain current face amount ☐ $ _____ Elect lower amount ☐ $ _____	**Spouse:** Retain current face amount ☐ $ _____ Elect lower amount ☐
Children (Dependent Term Life Insurance): Retain current face amount ☐ $ _____ Elect lower amount ☐ $ _____ **NOTE:** round down to the nearest $1,000	**Children:** Retain current face amount ☐ $ _____ Elect lower amount ☐ $ _____ **NOTE:** round down to the nearest $1,000

*Participants are eligible if they have been actively employed prior to leaving their employer, and they are not retiring or disabled.

5. Employee/Applicant Beneficiary Designations (to be completed by employee/applicant or assignee, if assigned)

A. PRIMARY BENEFICIARIES: Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries, or if the beneficiary is your estate or a trust. If there is no named beneficiary, or no named beneficiary survives the insured, settlement will be made in accordance with the terms of the Group Contract.

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship	Percentage
Street Address			Apartment #	City	State	ZIP
Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship	Percentage
Street Address			Apartment #	City	State	ZIP

B. CONTINGENT BENEFICIARIES: Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than five contingent beneficiaries.

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship	Percentage
Street Address			Apartment #	City	State	ZIP
Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship	Percentage
Street Address			Apartment #	City	State	ZIP
Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship	Percentage
Street Address			Apartment #	City	State	ZIP

6. Dependent Term Life Insurance Coverage - Spouse (to be completed by employee)

This section should only be completed if you previously had dependent coverage with Prudential for your spouse and you wish to continue this dependent coverage.
Note: With the exception of death and divorce, you must elect portability in order for your spouse to have portable coverage. The employee is the beneficiary for Dependent Term Life Insurance.

Is spousal coverage being ported due to the death of the employee or divorce? ☐ Yes ☐ No			Is spouse confined for medical care or treatment at home or elsewhere? ☐ Yes ☐ No	
Spouse's Last Name	First Name	MI	Social Security Number	Date of Birth

7. Dependent Term Life Insurance Coverage - Children (to be completed by employee)

This section should only be completed if you previously had dependent coverage with Prudential for your children and you wish to continue this dependent coverage. **Note: You must elect portability in order for your children to take portable coverage. The employee is the beneficiary for Dependent Term Life Insurance.**

Is any child confined for medical care or treatment at home or elsewhere?
☐ Yes ☐ No if yes, provide name of child _____

Youngest Child's Last Name	First Name	MI	Social Security Number	Date of Birth

8. Employee/Applicant/Assignee Signature(s) (to be completed by employee/applicant/assignee)

I hereby request coverage under the Group Term Life Insurance Portability Plan. I understand that I will be billed on a quarterly basis and that a $3 billing fee per quarter will apply. I understand that, if I elect to convert my coverage to an individual policy, I waive my right to apply for coverage under the Portability Plan. I understand that my Group Term Life Insurance coverage will be subject to the rules of the group contract governing the Portability Plan. I also understand that I may apply for coverage under the Portability Plan subject to the following:

- This selection is made within 31 days of the date that I am no longer eligible for coverage through my former employer.
- Your coverage amount will reduce in accordance with the terms of the group contract.
- Generally, Group Term Life Insurance for my dependents is only available with my election of portable Group Term Life Insurance.
- Portability is not available if age 80 and over at the time of election.
- Group Term Life Insurance for my dependents ends when they no longer qualify as eligible dependents.
- Group Term Life Insurance and coverage under all applicable riders will end if I fail to make any payment needed to keep my coverage in force within 31 days from the date due.
- Rates may change as the insured enters a higher age category, or if plan experience requires a change for all insured. Rates will not be changed on an individual basis.

X		**X**	
Employee's/Applicant's Signature	*Date*	*Assignee's Signature (if applicable)*	*Date*

9. For Prudential Use Only

Effective Date of Coverage: |__|__|__|__|__|__|__|__| (mm/dd/yyyy)

*Participants are eligible if they have been actively employed prior to leaving their employer, and they are not retiring or disabled.

IMPORTANT NOTICE REQUIRED BY CERTAIN STATE REGULATORS:

For residents of all states except Florida, New Jersey, New York, Pennsylvania, Virginia and Washington;

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to accident coverage.

PENNSYLVANIA RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

WASHINGTON RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

*Participants are eligible if they have been actively employed prior to leaving their employer, and they are not retiring or disabled.

Prudential Financial

GROUP INSURANCE

The Prudential Insurance Company of America

Employer/Association Name:

Group Contract No(s): 0 0

Short Form Health Statement Questionnaire For Portability Only

Employee/Member First Name | MI | Last Name

Employee/Member Social Security Number

Applicant First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Date of Birth | Social Security Number

Sex ☐ Male ☐ Female | Height ft. in. | Weight lbs.

Please answer these questions by checking "Yes" or "No."

Yes ☐ No ☐ Do you **currently** have any disorder, condition (including pregnancy), disease, or defect or are you **currently** taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect other than a cold, cough, flu, or allergies?

Yes ☐ No ☐ **During the last five years**, have you been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment?

Yes ☐ No ☐ **During the last five years**, have you had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn?

Yes ☐ No ☐ **Within the last five years**, have you been diagnosed with, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or have you been treated for or had any trouble with any of the following: heart, chest pain, high blood pressure, cancer or tumors, diabetes, lungs, kidneys, liver?

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

IMPORTANT NOTICE:

In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, Washington, and the District of Columbia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee, and the District of Columbia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding, or attempting to defraud, the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding $5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines, and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

In Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In New Jersey: Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

In Virginia: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company has committed a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

In Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may subject such person to criminal and civil penalties.

In Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

In Washington: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Applicant's Signature (unless a minor) Date

If applicant is a minor, Signature of Parent, Guardian, or Person Liable for Support of Applicant Relationship Date

Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

  The Prudential Insurance Company of America
  Group Medical Underwriting
  P.O. Box 8796
  Philadelphia, PA 19176

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112, (617) 426-3660.

Please keep this notice for your records.

Prudential Financial

GROUP INSURANCE

The Prudential Insurance Company of America

Employer/Association Name:

Group Contract No(s): 0 0

Short Form Health Statement Questionnaire For Portability Only

Employee/Member First Name | MI | Last Name

Employee/Member Social Security Number

Applicant First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Date of Birth | Social Security Number

Sex ☐ Male ☐ Female | Height ft. in. | Weight lbs.

Please answer these questions by checking "Yes" or "No."

Yes ☐ No ☐ Do you **currently** have any disorder, condition (including pregnancy), disease, or defect or are you **currently** taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect other than a cold, cough, flu, or allergies?

Yes ☐ No ☐ **During the last five years**, have you been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment?

Yes ☐ No ☐ **During the last five years**, have you had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn?

Yes ☐ No ☐ **Within the last five years**, have you been diagnosed with, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or have you been treated for or had any trouble with any of the following: heart, chest pain, high blood pressure, cancer or tumors, diabetes, lungs, kidneys, liver?

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- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
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I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Applicant's Signature (unless a minor) Date

If applicant is a minor, Signature of Parent, Guardian, or Person Liable for Support of Applicant Relationship Date

Group Life and Disability Income Medical Underwriting NOTICE

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- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

  The Prudential Insurance Company of America
  Group Medical Underwriting
  P.O. Box 8796
  Philadelphia, PA 19176

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Please keep this notice for your records.